

Medicaid Transformation Project Demonstration

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Terms used in this presentation

ACH	Accountable Community of Health
Apple Health	Washington State's Medicaid program
Demonstration	Shorthand: Medicaid Transformation Project demonstration
DSRIP	Delivery System Reform Incentive Payment
LTSS	Long-term Services and Supports
MAC	Medicaid alternative care
MCO	Managed Care Organization
Section 1115 waiver	A mechanism for obtaining federal funds not otherwise allowed under the Medicaid program
STCs	Special Terms and Conditions
TSOA	Tailored Supports for Older Adults

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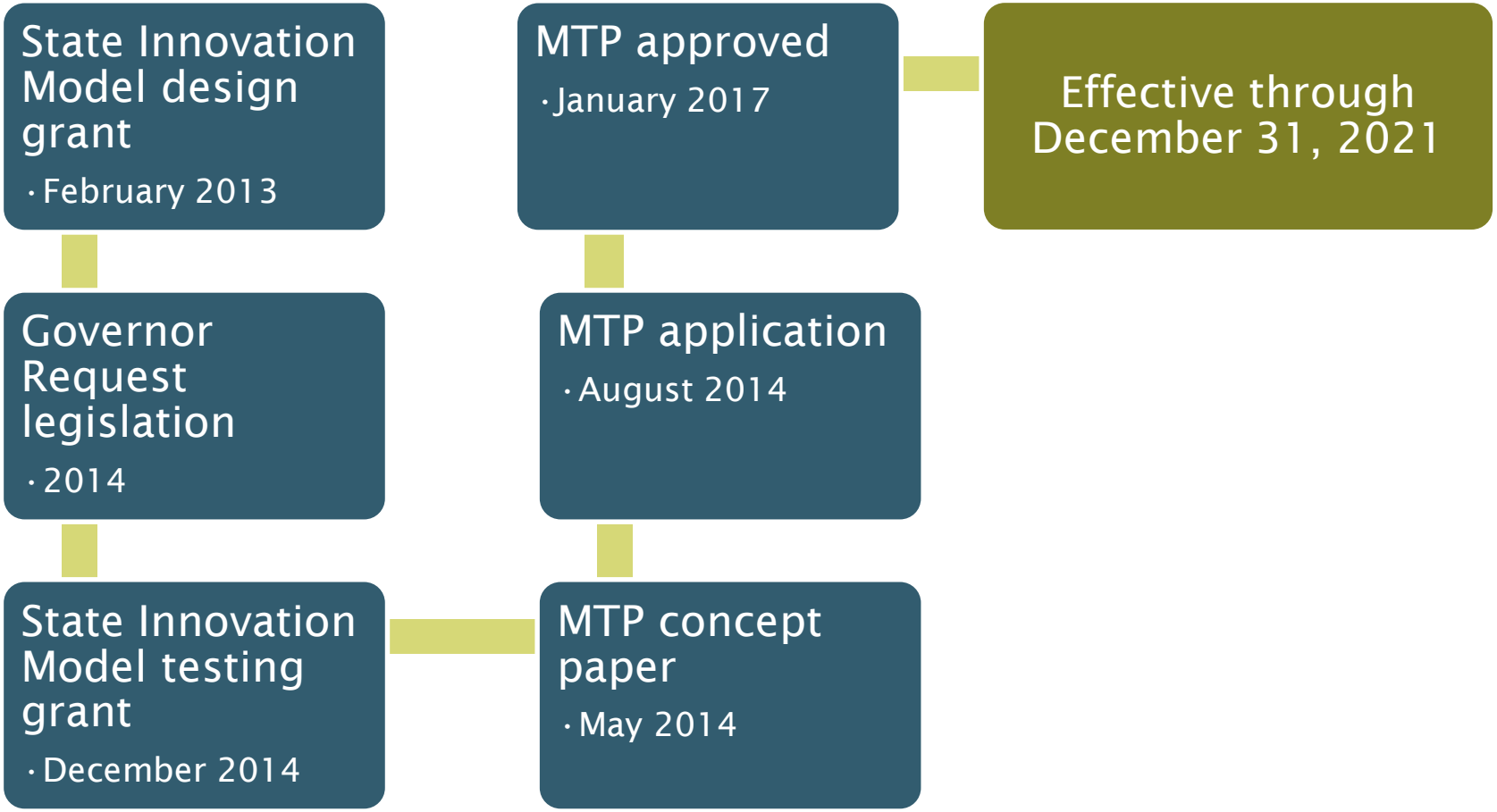
How we got here



Legislative directives for transformation

Washington enacted legislation furthering delivery system reform:

E2SHB 2572 (2014)

- Transforming the Health Care Delivery System

2SSB 6312 (2014)

- Fully Integrated Medicaid Managed Care

SHB 1879 (2015)

- Integrated Medicaid Managed Care for Foster Children

2ESHB 2376 / Subsections 213 (1)(d-g) (2016)

- Appropriation for Medicaid Transformation Demonstration Waiver Initiatives

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Who Medicaid serves

- Apple Health covers 1.9 million individuals
- 600,000 newly eligible adults under Medicaid expansion
- Populations served include children, pregnant women, disabled adults, elderly persons, and former foster care adults

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Medicaid transformation goals

Over the five-year demonstration, Washington will

- Integrate physical and behavioral health purchasing and service delivery
- Convert 90% of Medicaid provider payments to reward outcomes
- Implement population health strategies that improve health equity
- Provide targeted services that address the needs of our aging populations and address the key determinants of health

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5 years from now

Current system

- Fragmented care delivery
- Disjointed care transitions
- Disengaged clients
- Capacity limits
- Impoverishment
- Inconsistent measurement
- Volume-based payment

Transformed System

- Integrated, whole-person care
- Coordinated care
- Activated clients
- Access to appropriate services
- Timely supports
- Standardized measurement
- Value-based payment

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Section 1115 waiver

We refer to this as a demonstration because we are demonstrating that through innovative service delivery systems, we can improve care, increase efficiency, and reduce costs.

Section 1115 of the Social Security Act

- Secretary of HHS may waive provisions of major health and welfare programs through negotiations with states, generally for five-year periods
- Permits states to use federal Medicaid funds in ways not otherwise allowed under federal rules.
- New population, ways to expand programs, and innovation.

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Medicaid Transformation Project demonstration

- Five-year demonstration of innovative strategies to improve health outcomes and use resources wisely
- Authorizes up to $1.5 billion in federal investments
- Three initiatives:

Transformation through Accountable Communities of Health	Long-term Services and Supports	Foundational Community Support Services

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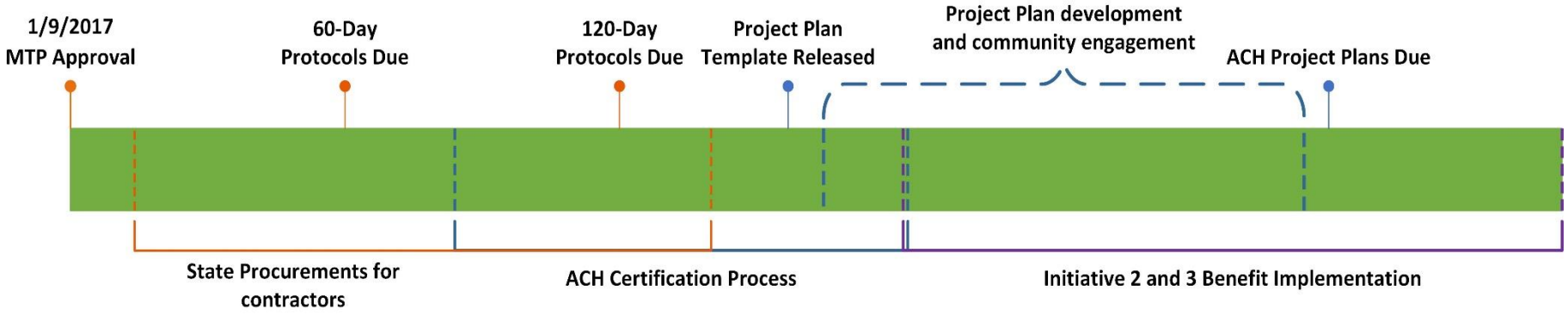
Implementation timeline

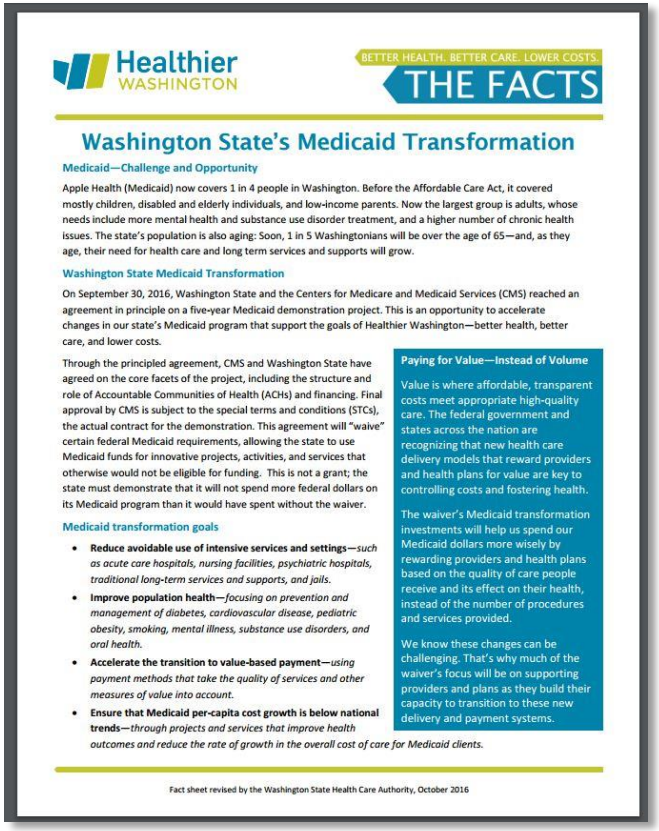


Learn more

Communications Library features:

- Demonstration video
- Fact sheets
- Timeline
- Slide presentations

www.hca.wa.gov/hw



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BETTER HEALTH. BETTER CARE. LOWER COSTS.

THE FACTS

Washington State's Medicaid Transformation

Medicaid—Challenge and Opportunity

Apple Health (Medicaid) now covers 1 in 4 people in Washington. Before the Affordable Care Act, it covered mostly children, disabled and elderly individuals, and low-income parents. Now the largest group is adults, whose needs include more mental health and substance use disorder treatment, and a higher number of chronic health issues. The state's population is also aging: Soon, 1 in 5 Washingtonians will be over the age of 65—and, as they age, their need for health care and long term services and supports will grow.

Washington State Medicaid Transformation

On September 30, 2016, Washington State and the Centers for Medicare and Medicaid Services (CMS) reached an agreement in principle on a five-year Medicaid demonstration project. This is an opportunity to accelerate changes in our state's Medicaid program that support the goals of Healthier Washington—better health, better care, and lower costs.

Through the principled agreement, CMS and Washington State have agreed on the core facets of the project, including the structure and role of Accountable Communities of Health (ACHs) and financing. Final approval by CMS is subject to the special terms and conditions (STCs), the actual contract for the demonstration. This agreement will "waive" certain federal Medicaid requirements, allowing the state to use Medicaid funds for innovative projects, activities, and services that otherwise would not be eligible for funding. This is not a grant; the state must demonstrate that it will not spend more federal dollars on its Medicaid program than it would have spent without the waiver.

Paying for Value—Instead of Volume

Value is where affordable, transparent costs meet appropriate high-quality care. The federal government and states across the nation are recognizing that new health care delivery models that reward providers and health plans for value are key to controlling costs and fostering health.

The waiver's Medicaid transformation investments will help us spend our Medicaid dollars more wisely by rewarding providers and health plans based on the quality of care people receive and its effect on their health, instead of the number of procedures and services provided.

We know these changes can be challenging. That's why much of the waiver's focus will be on supporting providers and plans as they build their capacity to transition to these new delivery and payment systems.

Medicaid transformation goals

- **Reduce avoidable use of intensive services and settings**—*such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional long-term services and supports, and jails.*
- **Improve population health**—*focusing on prevention and management of diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders, and oral health.*
- **Accelerate the transition to value-based payment**—*using payment methods that take the quality of services and other measures of value into account.*
- **Ensure that Medicaid per-capita cost growth is below national trends**—*through projects and services that improve health outcomes and reduce the rate of growth in the overall cost of care for Medicaid clients.*

Fact sheet revised by the Washington State Health Care Authority, October 2016

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Special Terms and Conditions

Special Terms and Conditions (STCs)

- The contract between the state and the Centers for Medicare and Medicaid Services (CMS)
  - Enables Washington to operate this demonstration
- The information contained in the STCs outlines the conditions and limitations of the demonstration.
- There are 13 sections which include 113 STCs.

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Please note

- The information provided in these slides is not a comprehensive overview of the STCs.
- Slides are intended to reflect the major elements included in the STCs to help our partners and stakeholders better understand the expectations for this demonstration.
- Full text of the STCs can be found online at www.hca.wa.gov/hw

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General Program Description and Requirements

Program description and objectives

Initiative 1: Transformation through Accountable Communities of Health

The demonstration aims to transform the health care delivery system through regional, collaborative efforts led by Accountable Communities of Health (ACHs)

- ACHs are regionally situated, self-governing organizations.
- ACHs are composed of managed care, provider, and many other community organizations and are focused on improving health and transforming care delivery for the populations that live within their region.
- ACHs will lead strategies consistent with transformation objectives based on a regional health needs inventory.

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Program description and objectives

Initiative 2: Long-term Services and Supports

Initiative 3: Foundational Community Supports

The demonstration will provide and assess changes to payment, care delivery models, and targeted services

- Medicaid alternative care (MAC)
- Tailored Supports for Older Adults (TSOA)
- Foundational Community Supports:
  - Supportive housing
  - Supported employment

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General program requirements

Standard contract terms for Section 1115 demonstrations are incorporated in STCs #1-19.

- Provides the legal and regulatory framework for implementing and operating the demonstration
- Includes required procedures for amendments to or phase out of the demonstration

Populations affected by the demonstration

Provides a description of the populations that are covered by the activities within this demonstration (STC 20):

All Individuals who are currently eligible under the state's Medicaid State Plan

Demonstration expansion population

- Individuals eligible for Tailored Supports for Older Adults (TSOA) who are not otherwise eligible for Categorically Needy (CN) or Alternative Benefit Plan (ABP) Medicaid, age 55 or older, meet functional eligibility criteria for Home and Community Based Services (HCBS)

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Delivery System Reform Incentive Payment (DSRIP) Program (Initiative 1)

Transformation through ACHs

Provides details and expectations for implementation of Initiative 1 of the demonstration (STCs 21-45):

Accountable Communities of Health

- The demonstration authorizes the ACHs to coordinate and oversee regional projects aimed at improving care for the Medicaid population

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A regional approach

Accountable Communities of Health

- Coordinate and oversee regional projects aimed at improving care for Medicaid beneficiaries
- Apply for transformation projects, and incentive payments, on behalf of partnering providers within the region
- Decide on distribution of incentive funds to providers for achievement of defined milestones
- Report on regional progress as required in the STCs

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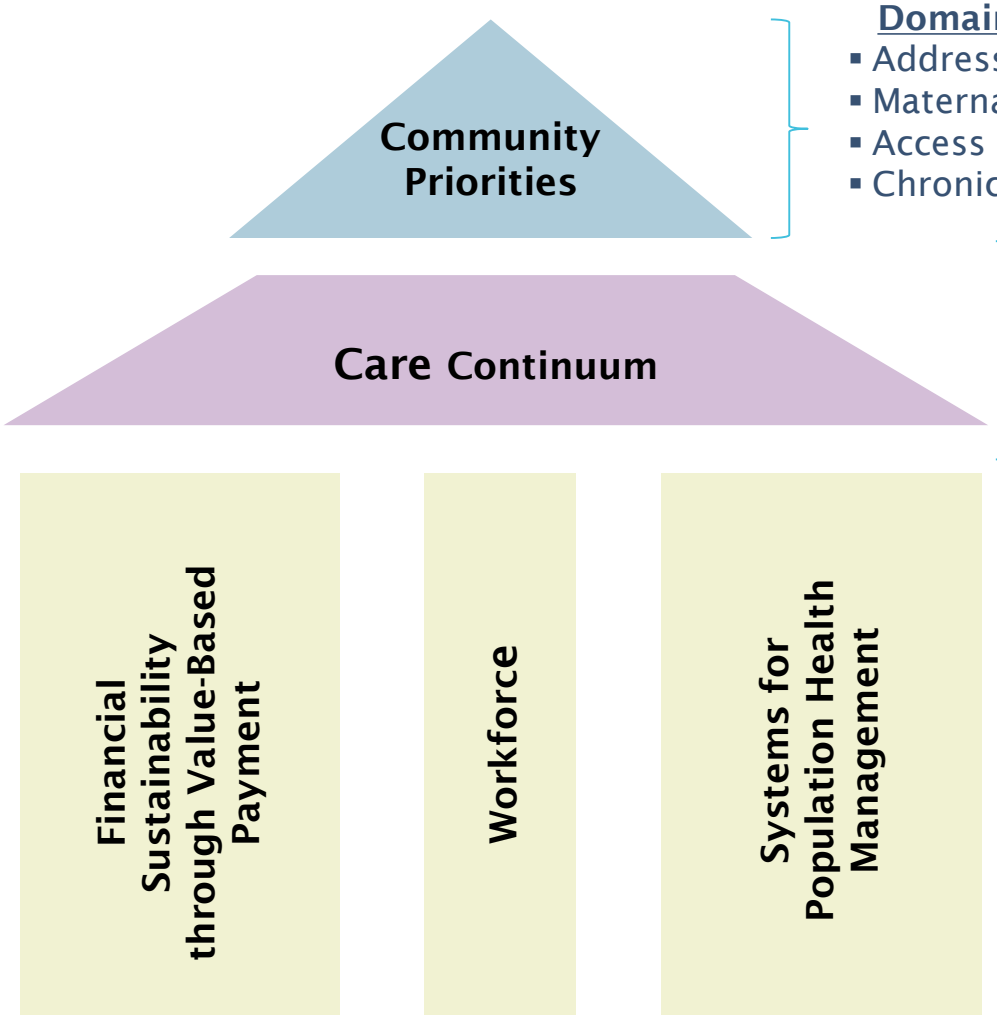
The Project Toolkit



Domain 3: Prevention and Health Promotion

- Addressing the opioid use public health crisis
- Maternal and child health
- Access to oral health services
- Chronic disease prevention and control

Domain 2: Care Delivery Redesign

- Bi-directional integration of care and primary care transformation
- Community-based care coordination
- Transitional care
- Diversion interventions

Domain 1: Health Systems and Community Capacity Building

- Financial sustainability through value-based payment
- Workforce
- Systems for population health management

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Independent assessor

State-contracted vendor

- Will serve as independent assessor for delivery system reform activities under the demonstration
- The state will develop the tool that the vendor will use in evaluating project plans.
- Cannot have an affiliation with Accountable Communities of Health or their partnering providers

Independent assessor responsibilities

- Reviewing Accountable Communities of Health Project Plan applications
- Providing recommendations to state regarding approval, denial, or recommended changes to ACH Project Plans
- Assessing project performance throughout the demonstration

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Financial executor

State-contracted vendor

- Provides centralized management and accounting for transformation project incentive funds
- Avoids variation in payment arrangements across Accountable Communities of Health
- Provides central accountability to state for managing transactions
- Responsible for distributing incentive dollars to providers participating in transformation projects once milestones are achieved

Roles for Approval Process and Funds Flow

Independent Assessor

- Works with the state to develop application/project review tool
- Recommends approval/denial to the state
- Monitors performance to determine funding based on semi-annual report

Financial Executor

- Disburses funds to partnering providers based on ACH direction
- Funds flow when goals are achieved
- Reports on fund balances and disbursements

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STC #24

Tribal engagement and collaboration

STCs 24-STC 26 pertain to tribes.

Tribal engagement with ACHs

- Provides expectations around Tribal and ACH engagement
- ACHs must adopt either the State's Model ACH Tribal Collaboration and Communication Policy or an alternate policy agreed upon in writing.

Tribal collaboration protocol

- A Tribal protocol will include a greater level of detail and incorporated in the STCs as *Attachment H.*
- Protocol will list the objectives the state and tribes seek in order to achieve tribal specific interests in Medicaid Transformation.
- The process and funding mechanics for any tribal specific projects included in the demonstration

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Tribal specific terms

Tribal coordinating entity (TCE)

- The state will support a tribal coordinating entity (TCE) controlled by tribes and Urban Indian Organizations for purposes of facilitating engagement and coordination with tribal governments and communicating advice/feedback from Indian Health Care Providers (IHCPs).
- The state will work with the TCE to assess the demonstration for impacts, including unintended consequences, on affected IHCPs and AI/AN.

Tribal specific terms

Tribal specific projects

- Provide an opportunity for tribal specific projects if there are tribal needs that cannot be addressed by the strategies within the Project Toolkit
- Are required to align with the objectives of the demonstration and are still subject to CMS approval
- Would not be coordinated by ACHs

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Role of Managed Care Organizations

MCO role and responsibilities in DSRIP

- Support the ACHs in regions where an MCO is providing services; this can be by serving in a leadership capacity or other supportive capacity MCOs do not need to serve on every committee or workgroup that an ACH has identified.
- Participate in the design and implementation of transformation projects
- Collaborate with provider networks to implement VBP models

DSRIP project objectives

Requirements for transformation projects (STC 30):

Transformation project objectives

- Health systems & community capacity building
- Financial sustainability through value-based payment
- Bi-directional integration of physical and behavioral health
- Community-based whole person care
- Improve health equity and reduce health disparities

Project Toolkit

- The Toolkit domains and project categories include the available activities and strategies necessary to achieve the project objectives specified.
- The toolkit will be included in the DSRIP Planning Protocol.

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DSRIP project milestones

Three categories of milestones can trigger incentive payments under a transformation project (STC 31):

Project planning progress milestones – "Pay for Planning"

- Initial planning activities and partnerships that establish foundational structure and capacity for transformation project goals

Project implementation planning – "Pay for Reporting"

- Action steps taken by participating providers specified in the project's initial planning activities

Scale and sustain – "Pay for Outcomes"

- Demonstrable progress towards project outcomes made by participating providers due to the implementation of the project plan

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STC #34

DSRIP Planning Protocol

The state will submit the DSRIP Planning Protocol to CMS in March. It will be incorporated in the STCs as Attachment C (STC 34):

DSRIP Planning Protocol will include

- Requirements for ACH Project Plan applications including timelines
- Project Toolkit and related milestones and metrics
- Process that ACHs will follow for potential Project Plan modifications over the course of the demonstration
- Process for establishing baseline data and process for ongoing data reporting

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STC #35

DSRIP Funding and Mechanics Protocol

The state will submit the DSRIP Funding and Mechanics Protocol to CMS in March. It will be incorporated in the STCs as Attachment D (STC 35):

Funding and Mechanics Protocol will include

- The formula/methodology to determine project funding allocation. Payment will be commensurate with:
  - Parameters and requirements for ACH budget plans which will determine how funding will be distributed to partnering providers
- An overview of the two phases of the certification process ACHs must complete to be eligible for Project Design funds

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Allocating funds for projects

Considerations in building the allocation model

- Number of Medicaid beneficiaries served
- Relative impact of the proposed project (e.g., capacity building activity vs. opioid use intervention)
- Number, type and scale of projects undertaken in a given region

Model submission

- Model will be submitted by March 10 as a protocol to be approved by CMS

Budgeting & payments

- Model will guide budgeting by ACH region
- Actual payments to providers will be made upon achievement of defined milestones

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STC #36

ACH Project Plans

Elements to be included in project plans is further detailed in (STC 36)

ACH Project Plan applications

- ACHs must submit a Project Plan application to the state and independent assessor for approval.
- The state will outline the ACH Project Plans in the DSRIP Planning protocol and also develop a project plan template.
- It's anticipated that Project Plans will be submitted by ACHs in the fall of DY1 and approved by the end of the year.
- ACHs must solicit and incorporate community and consumer input to ensure project plans reflect the needs of the region.

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ACH Project Plan applications

Project plan applications must include key elements.

Project selection and implementation

- Detail which projects the ACH, through its partnering providers, will implement
- Describe the community need that is being addressed through the project and how the implementation of that project will achieve the desired outcomes
- Provide assurances that projects chosen in the region are new, or will significantly enhance, existing health care initiatives

ACH Project Plan applications

Project plan applications must include key elements.

Community and consumer engagement

- Detail of efforts to solicit and incorporate community and consumer input to ensure Project Plans reflect the specific needs of the region
- Summary of at least two public meetings to gather public feedback
- Documentation of how public comments were incorporated into the final version of the Project Plan
- Process for ongoing community and consumer engagement over the course of the demonstration

ACH Project Plan applications

Project plan applications must include key elements.

ACH management and budget planning

- ACHs must demonstrate compliance with STC 22
- Identify a primary decision-making process
- Documented process for conflict resolution
- Confirmation that governance composition complies with STC 23
- A high-level overview for how the ACH will approach decisions for incentive payment allocation for metrics and milestones

STC #40

Value-based payment roadmap

Instructs the state to include, and update annually, a VBP roadmap (STC 40). Annual updates will reflect best practices and lessons learned.

VBP roadmap includes

- VBP attainment targets
- Details for financial incentives available for MCOs and ACH partnering providers for achieving targets
- Summary of how managed care is transforming to support new models of care

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Models of Value-based payment

A key element of this demonstration is to support the payment reforms necessary for a high quality and financially sustainable Medicaid delivery system.

To support the move towards value-based payment, the state has established goals that are consistent with the HCP-LAN Alternative Payment Models (APM) Framework.

VBP GOALS (Consistent with HCP-LAN Framework)					
	DY1	**DY2**	**DY3**	**DY4**	**DY5**
HCP-LAN Category 2C-4B	30%	50%	75%	85%	90%
Subset of goal above: HCP-LAN Category 3A-4B	-	10%	20%	30%	50%
Payments in Advance APMs			TBD	TBD	TBD

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Life cycle of the 5-year DSRIP program

Protocol development (60-120 days)

STC 45 provides a synopsis of anticipated activities planned for this demonstration and the corresponding flow of funds.

Year 1

- Vendor contracting
- ACH certification & initial funding
- Project applications
- Project approval

Years 2-3

- Project initiation
- Project assessment & payments

Years 4-5

- Project fulfillment
- Project evaluation & sustainability
- Funding dependent fully integrated care

Value-based payment milestones →

Process measures → Outcome measures

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Long-term Services and Supports (Initiative 2)

Caregiving: impacts on family

- In Washington State, approximately 80% of the care statewide is provided by family members and other unpaid caregivers.
- Unpaid caregiving has an economic impact on families:
  - Loss of earning potential
  - Decreased savings for retirement
  - Impacts on ability to provide for their own children's needs
  - Increased health care costs due to stress and burden
- If one-fifth of unpaid caregivers stopped providing care, it would double the cost of long-term services and supports in Washington.

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Medicaid Alternative Care (MAC)

A new Long-term services and supports (LTSS) choice individuals may choose instead of traditional LTSS services (STC 46).

MAC Eligibility:

- Age 55+
- Eligible for categorically needy or alternative benefit plan medical
- Meet Nursing facility level of care (NFLOC)

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STC #47

Medicaid Alternative Care (MAC)
Benefits

MAC benefits are to support individuals and their unpaid caregivers (STC 47).

MAC Services:

- Caregiver Assistance Services: Services that take the place of those typically performed by the unpaid caregiver in support of unmet needs
- Training and Education: Services and support to assist caregivers with gaining skills and knowledge to implement services needed by the care receiver or to maintain their caregiving role
- Specialized Medical Equipment: Goods and supplies needed by the care receiver
- Health Maintenance and Therapy Supports: Clinical or therapeutic services that assist the care receiver to remain in their home or the caregiver to remain in their caregiving role

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STC #48

Tailored Supports for Older Adults (TSOA)

Establishes a new Medicaid eligibility category for individuals at risk of future Medicaid LTSS eligibility (STC 48).

- Benefits to support an individual's unpaid caregiver or to offer a limited Personal care benefit to an individual without a caregiver
- Does not provide a medical benefit

TSOA Eligibility:

- 55+
- Not currently eligible for CN or ABP Medicaid
- Meet nursing facility level of care
- Have income up to 300% SSI Federal benefit rate
- Resource Limit: $53,100 for individual, includes the spousal resource limit for a married couple

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STC #49

Tailored Supports for Older Adults (TSOA)
Benefits

- Individuals eligible for Medically Needy or Medicare Savings Plan (MSP) are eligible for this new benefit
- Individuals who become CN or ABP Medicaid eligible will no longer be eligible for TSOA

TSOA Services

- Includes all benefits listed in the MAC benefit in (STC 47)
- Personal Assistance Services: supports involving the labor of another person, offered in lieu of Caregiver Assistance Services

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Home and community-based rules

Person Centered Planning

- State will use person-centered planning processes to identify participants', applicants' and unpaid caregivers' LTSS needs, the resources available to meet those needs, and to provide access to additional service and support options as needed.
- Must comply with 42 CFR 441.301(c)(1)-(3).

Self-directed supports

- The state will provide resources to support participants or their proxies (e.g., a surrogate, parent or legal guardian/representative) in directing their own care when that care is provided by an individual provider.
- The State assures background checks will be available.

Conflict of Interest

- The entity responsible for assisting the individual with development of the person-centered service plan may not be an LTSS service provider, unless that service planning entity is the only qualified and willing entity available to conduct the service.
- The state assures that conflict of interest protections will be in compliance with the characteristics set forth in 42 CFR 441.301(c)(1)(v)(vi).

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Home and community-based rules

Home and community-based setting requirements

- The state will ensure compliance with the characteristics of home and community-based settings in accordance with 42 CFR 441.301(c)(4), for those services that could be authorized under sections 1915(c) and 1915(i).

Quality measures

- The state is required to report the same performance measures for MAC and TSOA as would be reported in a 1915(c) or 1915(i) state plan amendments.

Critical incident reporting

- The state has a system, policies, and procedures in place through which providers must identify, report and investigate critical incidents that occur within the delivery of MAC and TSOA.
- Provider contracts reflect these requirements.

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Presumptive eligibility

The state may provide MAC and TSOA services to individuals during a presumptive eligibility (PE) period following a determination by the state or a qualified entity—on the basis of preliminary information (STC 56).

To receive services ongoing a full Medicaid or TSOA determination must be completed.

Qualified Entity

- Entity designated by the state to provide limited eligibility functions. Includes AAA and state designated tribal entities

Qualified Staff

- Staff must complete training, have a college degree and social service experience to conduct presumptive eligibility screens.

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Presumptive eligibility

Presumptive Functional

- The state or qualified entity will screen individuals to see if they meet nursing facility level of care as defined in state rule.

Presumptive Financial

- MAC: The state or qualified entity will confirm the individual is eligible for CN or ABP Medicaid.
- TSOA: The state or qualified entity will confirm via attestation that an individual is:
  - A state resident
  - Has a SSN or is establishing one
  - The individual's separate non-excluded income is equal to or less than the Special Income Level (SIL)
  - Non-excluded resources are below $53,100 for individual or for a married couple, that joint non-excluded resources are at or below a combination of $53,100 plus the current state Spousal Resource Standard using spousal impoverishment protections

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Presumptive eligibility

Period of PE

- Begins the date in which the individual is determined presumptively eligible
- Ends the date the individual is determined eligible for Medicaid or TSOA or the last day of the month following the month the determination was made if no application is received

PE Service Level

- No limit to services
- The state must concurrently assess the individual for both functional and financial eligibility.

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Estate recovery

Participants in MAC and TSOA are exempted from Medicaid estate recovery requirements (STC 57).

- This means that the state will not recover from the client's estate the costs incurred in providing these benefits.

Wait list

Helps ensure those receiving MAC and TSOA services will maintain access in the event demand for services outpaces available funding (STC 58).

- If the wait list is implemented the state must ensure no individual loses services.
- The ability to do presumptive eligibility stops if a wait list is implemented.

Foundational Community Support Services (Initiative 3)

Foundational Community Supports

What it is

- Targeted Medicaid benefits that help eligible clients with complex health needs obtain and maintain housing and employment stability
  - Supportive housing services
  - Supported employment services

What it isn't

- Ongoing payments for housing, rent, or room & board costs
- Wages or wage enhancements for clients
- Entitlement

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Foundational Community Supports

Provides authority for Supportive Housing and Supported Employment benefits.

Community Transition Services

- One-time supports for individuals transitioning out of institutions or at imminent risk of becoming institutionalized
- Includes rental deposit, move-in costs, necessary furnishings and other necessary supports

Community Support Services

- Housing assessment and development of a plan to address barriers
- Assistance with applications, community resources, and outreach to landlords
- Education, training, coaching, resolving disputes, and advocacy

Supportive housing services do not include funds for room and board or the development of housing.

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Foundational Community Supports

- Service definitions, provider qualifications, and payment methodologies will be specified in FCS Protocol (Attachment I).
- ***Wait list:*** Helps ensure those receiving services will maintain access in the event demand for services outpaces available funding
  - If the wait list is implemented the state must ensure no individual loses services.

Foundational Community Supports

Next steps

- Foundational Community Supports protocol
  - *Service descriptions*
  - *Provider qualifications*
  - *Needs assessments*
  - *Payment methodologies*
- Protocol will be submitted to CMS for review and approval Spring 2017
- Protocol must be approved by CMS before services can be provided

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General Financial Requirements and Demonstration Evaluation

General reporting requirements

Quarterly Operational Reports

- Progress reports on demonstration expenditures
- Budget neutrality status
- Public engagement activities
- Update on provider progress toward milestones
- Summary of ACH project plan analysis including achievements and barriers
- Evaluation activities and findings

Annual Reports

- Documenting accomplishments
- Status of projects
- Case study findings
- Utilization data
- Policy and administrative barriers
- Final Report due 120 days after conclusion of the demonstration period

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Federal funding sources

Designated state health programs (DSHP)

- State or locally funded health care programs which serve low-income and uninsured people and are not otherwise eligible for federal matching funds
- Programs leveraged as a DSHP will continue to operate just as they would if they were not a designated DSHP
- Total allowable DSHP = $928,481,856 over 5 years
- Annual DSHP is phased down from $240m in DY1 to $124.6m in DY5
- Starting in DY3, a portion of DSHP funding will be at risk based on statewide DSRIP performance metrics.

Intergovernmental transfers (IGT)

- Transfers of public funds between governmental entities (e.g., from a county or public hospital to the state
- Source of funding must be reviewed to ensure it meets federal requirements for permissible transfers
- Public/governmental entities that are eligible, willing and financially able to contribute funds through an IGT will partner with regional Accountable Communities of Health to develop transformation project plans
- IGT funding will increase over the 5 year demonstration as the DSHP phases down

Designated State Health Programs (DSHP)

Expenditures ineligible for DSHP will be further detailed in the DSHP Claiming Protocol (STC 92)

Examples include:

- Grant funding to test new models of care
- Construction costs (bricks and mortar)
- Room and board expenditures
- School based programs for children
- Debt relief and restructuring
- HIT/HIE expenditures
- Services provided to undocumented individuals
- Research expenditures
- Rent and/or Utility Subsidies that are normally funded by other federal programs
- Services for incarcerated individuals
- Administrative costs
- Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans)
- Funds from other federal grants

Monitoring Budget Neutrality

A challenging aspect of Section 1115 demonstrations is establishing that it will be budget neutral (STCs 95-106).

- A demonstration is considered budget neutral if the total federal funding the state receives for the demonstration does not exceed what the state would have received without the demonstration.
- To determine the total amount of funding available through a Section 1115 authority, CMS uses a budget model known as the budget neutrality (BN) limit.

Budget neutrality

Federal expenditures

- Must be at or below what they would be without the waiver

"Without Waiver" vs "With Waiver"

- State must measure projected "without waiver" (WOW) expenditures against "with waiver" (WW) expenditures
- Difference between WOW and WW expenditures creates the budget neutrality "room" within which federal funds are made available

Measurement

- Budget neutrality is measured annually but enforced over the five-year lifetime of the demonstration

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Evaluation of the demonstration

The standards and requirements for conducting the evaluation of the demonstration (STCs 107-113).

Evaluation design provides

- Description of expectations for draft evaluation design
- Hypotheses to be tested in the evaluation
- Domains of focus
- Minimum research questions to address in the evaluation
- Expectation of state cooperation should CMS undertake an independent evaluation of any component of the demonstration

Evaluation of the demonstration

An independent evaluator must conduct the evaluation. A description of the state's process to contract with an independent evaluator will be included in the evaluation design.

Evaluation deliverables

- Draft evaluation design
- Interim evaluation report
- Final evaluation report

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Schedule of deliverables

Section XII provides a list of deliverables and associated due dates that the state must develop and submit to CMS for approval.

Deliverables

- As directed by STCs, the state is required to provide additional programmatic details and funding mechanics for the demonstration.
- The protocols as they are referred to, will include the programmatic information.
- There are 7 protocols that the state will develop and submit to CMS.
- Once approved, these protocols are included as attachments to the STCs.

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